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Transcript

Accelerating Innovative Cervical Cancer Care
January 25, 2024, 1:00 – 2:00 pm EST
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- American Association of Nurse Practitioners. (2022). Issues at a glance: Full practice authority. *American Association of Nurse Practitioners*, Policy brief. https://doi.org/https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief
- American Nurses Association. (2022, June 11). *Our racial reckoning statement*. https://www.nursingworld.org/practice-policy/workforce/racism-in-nursing/RacialReckoningStatement/
- Artiga, S., & Kaiser Family Foundation). (n.d.). *Racial disparities in health and health care* [PowerPoint presentation by the Vice President and director]. https://doi.org/https://content.naic.org/sites/default/files/call_materials/KFF%20Presentation.pdf
- Centers for Disease Control and Prevention. (2022, March 9). *National center for health statistics: Healthy People 2020 overview of health disparities*. CDC. https://www.cdc.gov/nchs/healthy_people/hp2020/health-disparities.htm
- Gontscharow, Z. (2022, September 23). *ANA brings nurses' voices to health equity priorities*. ANA Capitol Beat. https://anacapitolbeat.org/2022/09/23/ana-brings-nurses-voices-to-health-equity-priorities/
- Patton, R., & Zalon, M. (2014) *Nurses making policy: From bedside to boardroom (*1st ed.). Springer Publishing Company

Resources Shared by Su Clinica Women's Health Center

- Low-Cost, high-resolution imaging for detecting cervical precancer in medically underserved areas of Texas; Low-cost, high-resolution imaging for detecting cervical precancer in medically-underserved areas of Texas - PubMed (nih.gov)

Resources Shared by Su Clinica Women's Health Center (continued)

- Salcedo M.P., Gowen R., Rodriguez, A.M., et al, Addressing high cervical cancer rated in the Rio Grande Valley along the Texas-Mexico border; a community-based initiative focused on education, patient navigation, and medical provider training/telementoring, Perspectives in Public Health. Published Online. 2021 doi: 10.1177/1757913921994610.; https://pubmed.ncbi.nlm.nih.gov/34130548/
- A Comprehensive Program to Improve Treatment of Precancerous Cervical Lesions in the Rio Grande Valley of Texas; Copyright © 2023 Wolters Kluwer Health, Inc.

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Helenka Ostrum: Hello everyone, thank you for joining today's webinar, Accelerating Innovative Cervical Cancer Care.

Helenka Ostrum: My name is Helenka Ostrom and I'm a public health analyst with the Health Resources and Services Administration, in the Office of Women's Health. Please introduce yourselves in the chat with your name and organization.

Helenka Ostrum: I will now play a welcome message from Bethany Applebaum, the acting director of the HRSA Office of Women's Health.

Bethany Applebaum: This event is held in observance of Cervical Health Awareness Month and was developed in collaboration with HRSA's Bureau of Primary Health Care and the Veterans Affairs Health Center System. This webinar is part of the Office of Women's Health Leadership Series, which features public health experts, including HRSA grantees and stakeholders, spotlighting emerging issues and innovations in women's health across the lifespan.

Bethany Applebaum: Before we get started with today's speakers, I wanted to briefly share a bit about our agency for those of you who may be unfamiliar with our work.

Bethany Applebaum: The Health Resources and Services Administration is a component of the U.S. Department of Health and Human Services. We support a broad range of over 90 programs to provide healthcare to people who are geographically isolated and economically or medically vulnerable.

Bethany Applebaum: Every year, HRSA program support tens of millions of people, including those with low incomes, people with HIV, pregnant people, children, parents, rural communities, transplant recipients, and other communities in need as well as the health workforce, health systems, and facilities that care for them.

Bethany Applebaum: Within my office at HRSA, HRSA OWH, we lead and promote innovative sex and gender responsive public health approaches. We are part of a network of women's health offices throughout the Department of Health and Human Services and we work together with our colleagues to improve the health and safety of women across the lifespan.

Bethany Applebaum: Since 2021, HRSA and our federal partners have co-sponsored the Federal Cervical Cancer Collaborative. This Collaborative bridges federal priorities of cancer research at the National Cancer Institute and healthcare delivery by HRSA-supported safety-net settings of care. The FCCC supports the Cancer Moonshot on the National Cancer Plan.

Bethany Applebaum: The FCCC is the first partnership formed across HHS to improve cervical cancer care in safety-net settings The FCCC has developed a variety of resources, including most recently a toolkit to build provider capacity. Providers can use the toolkit to improve equitable cervical cancer prevention, screening, and management. The toolkit is available on the HRSA OWH website at www.HRSA.com/office-womens-health.

Bethany Applebaum: Today's webinar will highlight innovations in cervical cancer prevention and screening. We'll first hear from the VA about a new innovative form of screening, HPV self-sampling. Then we will hear from two accelerating cancer screening grantees. They will share how HRSA-supported health centers are increasing equitable access to cancer screening and referral for care and treatment.

Bethany Applebaum: We've set aside a few minutes for questions at the end. So please use the Q&A box to raise questions throughout today's presentation.

Bethany Applebaum: The presentation and transcript will be made available on the OWH website after today's event. Thank you again for joining us today. And I will now turn it back to Helenka who will introduce our next speaker.

Helenka Ostrum: It is now my pleasure to introduce Jannette Dupuy, the Quality Director in the Office of Quality Improvement to provide a welcome on behalf of the HRSA Bureau of Primary Health Care.

Jannette Dupuy: Thanks so much, Helenka and good afternoon to everyone. On behalf of the Bureau of Primary Health Care, we are so excited to be a part of today's webinar, honoring both Cervical Cancer Awareness Month and also highlighting some of the great work taking place across the Health Center Program as it pertains to cancer screening across the health centers.

Jannette Dupuy: As many of you know, cancer is the second leading cause of death in the United States with nearly 600,000 deaths annually.

Jannette Dupuy: In 2021 over 14,000 cervical cancers were diagnosed in women. Disruptions in cancer care during the COVID-19 pandemic resulted, as you all may know very well, in a reduction in cervical cancer screenings.

Jannette Dupuy: Disparities in cancer care were exacerbated during the pandemic across all of our vulnerable communities.

Jannette Dupuy: Health centers, a safety-net, were a key point of entry to screening for cervical cancer across and during the pandemic.

Jannette Dupuy: Health centers have found also that patient navigators and community health workers are effective in improving screening rates, reducing barriers to care, providing education, and advocating for services.

Jannette Dupuy: There's a need to increase the number of patient navigators and community health workers in the health centers to address the social determinants of health to have a greater impact on health disparities within the communities they serve. In 2022, there was over 4 million women screened for cervical cancer, equating to 54% of patients being tested.

Jannette Dupuy: That was a 1% increase from 2021 to 2022 of eligible women between the ages of 23 and 64 who were screened for cervical cancer. So, what are we doing specifically within the Bureau of Primary Health Care to increase cancer screening rates?

Jannette Dupuy: As many of you know and are familiar with, we were so happy to release our Accelerating Cancer Screening grants to assist 33 awardees who were focused on improving cancer screening. Amongst those, one of the goals that they focused on was cervical cancer.

Jannette Dupuy: The goals of this award were to increase equitable access to cancer screening and referral for care and treatment for populations served by health centers.

Jannette Dupuy: Also, another goal was to work in close partnership or coordination with the National Cancer Institute Designated Cancer Centers.

Jannette Dupuy: We were very excited about that. That would deploy outreach specialists and patient navigators. And also, to enhance patient education, case management, outreach, and other enabling services.

Jannette Dupuy: So, the first of its kind ever done an effort like this focused on cancer screening. And we are very proud and very excited of the accomplishments that our awardees have made in such a short amount of time.

Jannette Dupuy: We are now in our second year and are starting to see innovative ways to care. We've seen many specific health center activities related to cervical cancer as part of their award of their accelerating cancer screening grant.

Jannette Dupuy: System-wide changes that health centers have reported to us include leadership support and buy-in. EMR workflow changes to identify patients requiring cervical cancer screening and follow-up testing.

Jannette Dupuy: Patient navigation for follow-up of any abnormal test results. Increasing capacity to perform procedures such as colonoscopies by training providers.

Jannette Dupuy: There has also been an increase in access and addressing barriers. This has been seen through partnering with mobile units, partnering with cancer centers and their referral pathways to follow up on any abnormal test, collaboration with cancer centers for HPV self-testing, providing culturally competent care, and creating information communication materials in other languages so that all of our patients can understand the care they're receiving.

Jannette Dupuy: And tracking of referrals and understanding reasons for those. We are so excited today that we are going to be having on this presentation two of our accelerating cancer awardees presenting, both Blue Mountain and Su Clinica health center. We are truly excited, and we look forward to this new year in 2024 and all the exciting work, the wonderful progress that you all will make across the nation as it pertains to cancer screening.

Jannette Dupuy: So once again, thank you so much for your efforts in advancing not only cancer screening, but all the great work that you do across the nation to improve quality improvement across the health center program and also to serve the nation's most vulnerable and underserved.

Jannette Dupuy: I'll stop my opening remarks there and we are excited for this webinar. I'm sure as many of you are as well. I'll now turn the presentation back over to Helenka. Thank you.

Helenka Ostrum: Thank you so much for those welcome remarks.

Helenka Ostrum: I'd now like to introduce Dr. Elisheva Danan, a general internist and health services researcher at the Minneapolis VA Center for Care Delivery and Outcomes Research, and an Assistant Professor of Medicine at the University of Minnesota.

Helenka Ostrum: Her current research focuses on developing and implementing trauma-sensitive patient-centered primary and preventive health care practices for women who have experienced sexual assault.

Dr. Elisheva Danan: Thank you so much. Are you able to see my slides?

Helenka Ostrum: Yes. We can see them.

Dr. Elisheva Danan: Wonderful. Well, thank you for this opportunity to present our work on VA patient and staff perspectives on self-collected testing for human papillomavirus. I'm delighted to be here on behalf of all of my study team.

Dr. Elisheva Danan: We have no conflicts of interest to disclose. This study was funded by a K12 learning health systems career development award which was funded by the AHRQ and PCORI.

Dr. Elisheva Danan: As you all know, most cervical cancer cases are caused by persistent infection with cancer causing subtypes of the human papillomavirus, or HPV.

Dr. Elisheva Danan: Cervical cancer is nearly entirely preventable through vaccination and screening. And though both incidence and mortality have improved over time with routine screening, there are still over 14,000 new cases of cervical cancer and over 4,000 deaths annually in the US.

Dr. Elisheva Danan: Cervical cancer screening options are changing. Cervical cancer screening has traditionally required a pelvic exam with a speculum to collect cervical cytology or more recently cytology co-testing with HPV or testing for HPV alone.

Dr. Elisheva Danan: But primary HPV testing with a PCR test is so sensitive, it can now be done with a self-collected vaginal swab allowing women to collect a sample themselves without a pelvic exam in the initial screening test. Self-collected HPV testing is on the horizon.

Dr. Elisheva Danan: There is a growing global body of evidence that supports the use of self-collected HPV testing.

Dr. Elisheva Danan: It has comparable accuracy to clinician collected testing. Patients who are offered a self-swab are more likely to get their screening done than patients who are simply reminded to come in for a Pap. And overall patients who try it find it to be highly acceptable with most saying that they prefer self-collection to clinician collected testing.

Dr. Elisheva Danan: So, based on this evidence, self-collected HPV testing is currently in use in 17 countries, either as a primary screening method or as a strategy to reach under-screened women.

Dr. Elisheva Danan: It's currently under review by the FDA and the US Preventive Services Task Force and US availability is expected soon.

Dr. Elisheva Danan: Female veterans are a unique patient population that may find a particular benefit from self-collected testing. Female veterans have a high prevalence of common cervical cancer risk factors, including a high rate of smoking and a low rate of HPV vaccination.

Dr. Elisheva Danan: Female veterans also have a high prevalence of sexual trauma. Overall, 55% of women veterans who use the VA for their health care report experiencing sexual assault during their lifetimes, either as a child, an adult, or during military service.

Dr. Elisheva Danan: Which is significantly higher than the one-third of US women overall who report lifetime sexual assault. Among women veterans with a history of sexual trauma, nearly half report moderate or high levels of anxiety, distress, and discomfort with a pelvic exam.

Dr. Elisheva Danan: And 22% report that they've ever delayed a pelvic exam due to that distress.

Dr. Elisheva Danan: These are double the rates of distress and delay seen among women veterans with no history of trauma. So as a consequence of these elevated risk factors and potential barriers to screening, women veterans have a high prevalence of cervical dysplasia and HPV positivity.

Dr. Elisheva Danan: One in five received an abnormal result on their most recent screening test, which is significantly higher than the rate among non-veterans at 14%.

Dr. Elisheva Danan: Female veterans who receive their healthcare at the VA face additional challenges. Over half a million women across the country get VA healthcare.

Dr. Elisheva Danan: Women are the fastest-growing population of patients using the VA and their numbers have tripled in the past 15 years. Nevertheless, women are still only 8% of VA patients and VA facilities remain male-dominated environments.

Dr. Elisheva Danan: To respond to a women's growing health care needs, the VA has created a designation for specially trained women's health providers.

Dr. Elisheva Danan: But a quarter of women still see non-women's health providers, and they've been shown to screen for cervical cancer less reliably.

Dr. Elisheva Danan: In addition, a quarter of women veterans reported experiencing harassment from male veterans when they were at a VA facility in the past year.

Dr. Elisheva Danan: So, given women veteran's elevated individual level cervical cancer risk factors and the system-level barriers to care that we see in the VA, we believe self-collected HPV testing could be a promising new screening strategy for women veterans in the VA.

Dr. Elisheva Danan: To understand the potential role of self-testing in the VA, we ask the following research questions.

Dr. Elisheva Danan: What do veterans and VA staff think about self-collected HPV testing? What are the potential benefits and harms to veterans of introducing self-collection in the VA?

Dr. Elisheva Danan: We also evaluated potential benefits and harms to the healthcare system and the barriers and facilitators we might see with implementation, which we'll discuss in future papers.

Dr. Elisheva Danan: We conducted semi-structured qualitative interviews. Patient participants were recruited with flyers that we posted at the Minneapolis VA Health Care System and relevant staff members received individualized emails.

Dr. Elisheva Danan: All the interviews were completed by phone in 2021 and 2022. And our interview guides were informed by the Preventive Health Model and the CFIR framework.

Dr. Elisheva Danan: We used rapid qualitative analysis to analyze the patient and staff interviews separately and then we met as a research team to synthesize the findings and identify common themes.

Dr. Elisheva Danan: This research was considered IRB exempt and was conducted under oversight at the Minneapolis VA Research and Development Committee.

Dr. Elisheva Danan: Overall, we ended up with 22 patient participants and 27 staff participants. Our patients ranged in age from age 27 to 68.

Dr. Elisheva Danan: About half had a prior abnormal PAP result and about 40% identified as a race or ethnicity other than white.

Dr. Elisheva Danan: Our staff participants were local, regional, and national clinicians and administrators where clinicians included physicians and primary care, women's health and gynecology. Our nurses included RNs and LPNs and administrators were clinic and executive leadership in women's health, primary care, our patient experience office, preventive care, and laboratory medicine.

Dr. Elisheva Danan: We identified five overarching themes: High interest and enthusiasm. It's not for everyone. Self-testing is familiar and convenient. There are benefits for women with the history of sexual trauma. And reclaiming power and control.

Dr. Elisheva Danan: The first three themes shown in blue here, paralleled findings that have been seen with other patient and staff populations, while the last two in green seemed more specific to this population.

Dr. Elisheva Danan: I'm going to review each theme in a bit more detail and I'll provide you with some example quotes of what we heard.

Dr. Elisheva Danan: The first theme was high interest and enthusiasm tempered by questions about accuracy. Most patients and staff were immediately interested in what they saw as a commonsense patient-centered option.

Dr. Elisheva Danan: Patients thought that self-testing sounded convenient, private, and offered physical and psychological comfort. One patient said, “If there's no longer a speculum, we should have a parade.” Another said, “It's something that all veterans would be interested in. It feels very modern. It feels like healthcare with a patient in mind.”

Dr. Elisheva Danan: Staff members identified subgroups that they thought would really benefit from self-collection, such as those with the history of sexual trauma, transgender veterans, obese patients, and post-menopausal women.

Dr. Elisheva Danan: Here's one example of a staff member who thought a transgender patient of theirs would appreciate the option to do self-collection.

Dr. Elisheva Danan: Even enthusiastic participants had questions about accuracy and the ability to collect the sample correctly. Patients thought that it would be high stakes to do cervical cancer screening themselves and that they would need clear instructions.

Dr. Elisheva Danan: One woman said, “I'd be concerned that I was doing it correctly. There's the pressure of cancer. I'm depending on myself to do it right.” And staff members looked for official guidance about the evidence for self-collection, asking, “Is it as good as physician collected samples?”

Dr. Elisheva Danan: The second theme was it's not for everyone and there may be trade-offs for all. A minority of patients would not be a good fit for self-testing.

Dr. Elisheva Danan: Patients identify their own personal health histories or discomfort with self-touch. Stating, “I think I'd rather come in to get it done. I've had abnormal screenings before, so I just feel more confident if I had a Pap.”

Dr. Elisheva Danan: Another said, “I don't touch myself. I just honestly don't think that I would be comfortable with that.”

Dr. Elisheva Danan: Some members identified some trade-offs. Some patients would still need to do an exam and there could be missed opportunities to address reproductive health, build relationships, or identify incidental lesions.

Dr. Elisheva Danan: “A lot of things happen in the face-to-face setting. It could be really important to talk about military sexual trauma, see body language.” Or “We do find cervical polyps at times...condyloma... lichen sclerosus. These are the sorts of things we might start to miss more.”

Dr. Elisheva Danan: The third theme was self-testing is familiar and convenient. Even though this type of testing is new to cervical cancer screening, self-testing is not new. Patients thought it seemed simple and quick and described many other conditions for which they already self-test.

Dr. Elisheva Danan: They thought it'd be convenient to do this at home or in clinic. One woman said “They also have you do a stool exam. So, I could be doing my pelvic exam. I could send those in. I mean, I had to do my own COVID exam. These are very private natural things to do. People run pregnancy tests all the time. I'm diabetic, so I do my own glucose testing.”

Dr. Elisheva Danan: Staff members also drew parallels specifically to FIT testing or stool testing for colon cancer screening.

Dr. Elisheva Danan: They thought it would be convenient for rural veterans or clinics with fewer women clinicians. “We have a mechanism that we can do it because we routinely send FIT tests home. FIT is kind of a good comparison.”

Dr. Elisheva Danan: The fourth theme was benefits for women with a history of sexual trauma. Even though we never asked about it, sexual trauma came up repeatedly and spontaneously.

Dr. Elisheva Danan: Patients recognize that there was a high prevalence of sexual trauma among veterans. They describe their own personal experiences and those of friends and family members.

Dr. Elisheva Danan: They explain that invasive exams are uncomfortable and that they can be less comfortable to do at a VA facility.

Dr. Elisheva Danan: One woman said, “Just the past with the MST, or military sexual trauma, it's a hard thing. It's like a defense mechanism. After the experience of MST, it's totally different. I feel very like a violation, even though I know it's a professional. I know it's something that needs to be done. Not everybody is comfortable with somebody else looking at them or touching them.” And another woman

said, “There's a lot of sexual abuse that went on in the service and people don't like to come down to the VA.”

Dr. Elisheva Danan: One physician put it this way, “I've been practicing for 21 years, and I think our veteran patient population is very unique with the amount of trauma that they have experienced. It's probably been the most difficult population in which to perform these types of examinations. This is a particularly urgent need within our veteran population.”

Dr. Elisheva Danan: Finally, our final theme was reclaiming power and control. Self-collected HPV testing was seen as a form of patient empowerment.

Dr. Elisheva Danan: Patients explained that a pelvic exam is vulnerable and requires giving up bodily control and that military service is also associated with a loss of bodily autonomy.

Dr. Elisheva Danan: Self-collection could help return control to the patient. One woman said, “The stirrups just look like a control device. It just makes me think restraint. I've talked to other women, and they see the stirrups and like shit.”

Dr. Elisheva Danan: “I felt like I was in the military again, but this was a VA, right? So, it's a government facility, but it felt a little bit like I had no accounting over my body again. I mean, you know, you line up, they tell you to get a shot, you get a shot.”

Dr. Elisheva Danan: “I want that control back. Why do I have to give that control up to have a test done?” Amongst staff members, nurses in particular noted the value of giving patients back power over their own health.

Dr. Elisheva Danan: One nurse said, “I think that having that power in your own hand is really good for women in health care in general.”

Dr. Elisheva Danan: So, in summary, we present the first data exploring female veteran and VA staff perspectives on self-collected HPV testing.

Dr. Elisheva Danan: We found that female veterans and VA staff shared common perspectives about potential advantages and disadvantages of self-collected HPV testing.

Dr. Elisheva Danan: Where the benefits included improved comfort, convenience, and privacy. And the concerns were about accuracy and the ability to collect a sample correctly.

Dr. Elisheva Danan: They also identified veteran and VA-specific barriers to screening with a pelvic exam that could be addressed by self-collection. In particular, the high prevalence of sexual trauma among veterans and the potential for patient empowerment with self-collection.

Dr. Elisheva Danan: We concluded that self-collected HPV testing has the potential to improve trauma-informed preventive health care for veterans.

Dr. Elisheva Danan: And our future work will focus on designing and implementing a trauma-sensitive cervical cancer prevention program within the VA that incorporates self-testing.

Dr. Elisheva Danan: I'd like to acknowledge all of the veteran and staff interview participants, our Veterans Engagement Panel who helped with the design and analysis of this study, and the entire study team.

Dr. Elisheva Danan: I'm happy to take questions in the Q&A box and also feel free to follow up by email.

Helenka Ostrum: Thank you so much, Dr. Danan, for that wonderful presentation and overview of that HPV self-testing. I'm seeing a lot of accolades that are coming through.

Helenka Ostrum: I'd now like to introduce our next speaker. Sabrina Mitchell brings 30 years of nursing experience to her role as a Family Nurse Practitioner and Director of Nursing at Stone Mountain Health Services, Inc.

Helenka Ostrum: She has dedicated 30 years to public health where her experience includes APRN certified in Family Practice, C-suite roles in FQHC, Free Health Clinic outreach and community resources, Grant writing, Quality Improvement Coordination, Patient Center Medical Home Coordinator, Care Coordination subcommittee, Integrated behavioral/Medical coordination, VVFC Coordinator, Colorectal Cancer Subcommittee, Chair of the Board of Directors for Cenevia, Advisory Board Mountain Empire Community College Nursing Program, Advisory Board for Ridgeview Nursing Program.

Helenka Ostrum: Certifications and Memberships include the American Nurses Association Board Certified in Family Practice, Virginia Nurses Association, Sigma Theta Tau International Honor Society of Nursing, Southwest Virginia Community Advisory Board, Cancer Action Coalition of Virginia, and the American Association of Nurse Practitioners.

Helenka Ostrum: I'll now turn it over to Sabrina Mitchell.

Sabrina Mitchell: Good afternoon. I am Sabrina Mitchell and I'll be talking to you today about health disparities and how that patient navigators and the use of tracking refusals can help address barriers in cancer screenings and improve cancer screenings.

Sabrina Mitchell: I'm with Stone Mountain Health Services. Next slide, please.

Sabrina Mitchell: We are a federally qualified health center located in Southwest Virginia that involves 11 clinics that are primary care as well as two respiratory clinics.

Sabrina Mitchell: The project that I will be speaking with you about today is a quality improvement project and I'm honored to be able to speak on behalf of Stone Mountain Health Services about a project that was truly a team effort and took many individuals in order to be made available.

Sabrina Mitchell: That included patient participation, the leadership support of our administration, our providers, our nurses, front desk, staff, medical records, lab, and our performance improvement team as part of a quality improvement project.

Sabrina Mitchell: Next slide, please.

Sabrina Mitchell: We were already aware that disparities were being identified and that there was a call for support to address disparities and that was going to be done through collaboration.

Sabrina Mitchell: Next slide please.

Sabrina Mitchell: As a result, there was a call to mine data to find out more information about where these disparities were, how these disparities could be addressed, and where they could be identified.

Sabrina Mitchell: Next slide, please.

Sabrina Mitchell: So, barriers that were often identified included categories such as affordability, such as insurance coverage, accessibility such as transportation, geographical areas like rural areas, and then the availability of resources and the ability to access those quality services.

Sabrina Mitchell: And the ability to break that data down, we needed it to be meaningful so that we would be able to identify where these disparities existed.

Sabrina Mitchell: Next slide, please.

Sabrina Mitchell: We were also aware that the health system itself does not exist in a bubble alone, that it is affected by many different things, including the patient existing within the whole system and things are affecting that and contributing factors such as education, food insecurities that affect the healthcare system itself. Next slide, please.

Sabrina Mitchell: So, in order to address barriers and disparities, we were aware that ideas that had already been recommended was to expand access, to make data more meaningful in data collection, and to address social and economic conditions, and to address any discriminations that were available.

Sabrina Mitchell: So, we were all already aware of those needs. We were also already aware of what our rates were, based on the UDS collection that occurs every year within a federally qualified health system.

Sabrina Mitchell: Next slide, please.

Sabrina Mitchell: We were a recipient of the Accelerated Cancer Screening Grant and we're honored to be part of that.

Sabrina Mitchell: As a result, we were able to look at how can we improve our cancer screening rates. We had already identified the need and knew that there was a need there to do that.

Sabrina Mitchell: So, as a result of being a recipient, we were able to hire a patient navigator. And in hiring a patient navigator, we were able to develop a workflow process. And in developing that workflow process, we utilize the patient navigator as part of that process. But not only the navigator, as I talked about the team, we realized that the entire team needed to be involved in the process for cancer screening to improve and for us to identify the disparities and the barriers that were existing for our patient.

Sabrina Mitchell: As a result, a nursing triage tool was developed, and you can see that on the one side of the slide, in which the patient had the opportunity to fill this out through a patient portal.

Sabrina Mitchell: Also, there was an opportunity if the patient did not utilize electronics, they could fill it out in a paper format at the front desk.

Sabrina Mitchell: Also, when they presented for a visit, the nurse reviewed this, if it had not been filled out completed it, and this give us the opportunity to assess had the patient already had a screening and also to educate the patient on what screenings were recommended, what screenings were available, and to give them the opportunity to have those screenings.

Sabrina Mitchell: And in doing this, we found in that workflow process that there were several things that we also found we needed to address.

Sabrina Mitchell: Sometimes the patient had already had the screening done and as a result, we needed to get that within our system so that we could reflect within our data and to make our data meaningful that that test had been done. Sometimes it was that the patient didn't understand what that was or even that it needed to be done in which case we provided education to the patient. But oftentimes even with that education, the patient sometimes still refused.

Sabrina Mitchell: And as a result, that refusal is how we realized that we wouldn’t be able to identify some of the barriers as to why patients were not getting their screens done.

Sabrina Mitchell: We realized that patients often, it’s not that they don't necessarily want to have the screening done, often there are barriers that exist that are standing in the way of the patients getting that screening done.

Sabrina Mitchell: As a clinician, you would often hear, I know I'm doing the work, I don't understand why the numbers are not reflecting that.

Sabrina Mitchell: And even as, you know, as a nurse, the nurses would say, I know I'm doing the work. I don't understand why the numbers are not reflecting that. So, we began to track refusals to identify are we asking the patient, are we educating the patient? And then we wanted those refusals not just to tell us that they refused.

Sabrina Mitchell: We wanted to know why did they refuse. Was there a barrier that we needed to identify and address and be able to connect that patient with that resource.

Sabrina Mitchell: And that is the tool that you see on the other side of the slide. And that was also filled out.

Sabrina Mitchell: So once the patient refused, this tool would be utilized to track those refusals. Next slide, please.

Sabrina Mitchell: As a result of the quality improvement project, this was what the data revealed. And as I said, this continues to be an ongoing project.

Sabrina Mitchell: An astounding number of patients were refusing certain testing. We had cervical cancer screening alone had 151 patients that refused to have screening done.

Sabrina Mitchell: As addressed in the previous presentation, many times it's fear and anxiety that existed that the patient would not have this done for that reason.

Sabrina Mitchell: Sometimes in providing education to that patient that made us more aware or made the patient more aware what was going to be happening in that process.

Sabrina Mitchell: And the patient may change their mind from being a refusal to being able to get the test. Additionally, it also helped us identify what testing was more appropriate for that particular patient.

Sabrina Mitchell: Other barriers that included that the patient identified as why they were not having the testing done included financial barriers, also insurance barriers.

Sabrina Mitchell: In those situations, we could connect the patient with resources such as our outreach and enrollment specialists to help them identify what was available to them that they could get signed up with.

Sabrina Mitchell: Sometimes it was fear of the prep itself where we could educate the patient. Maybe it was transportation. And in those cases, we identified resources in our area that we could connect the patient with so that they could get to the clinics to be able to get those screenings done or to be able to get to the diagnostic center in order to get the mammograms or the colonoscopies done.

Sabrina Mitchell: And as I said, sometimes it was the fear and anxiety and identifying which test was most appropriate. Was the Cologuard more appropriate for the patient or as the presentation before explained about the self-testing for HPV at home and we were offering that as well.

Sabrina Mitchell: Next slide, please.

Sabrina Mitchell: As a result of this patient having the patient navigator and identifying the barriers, we identified that we needed to create a resource directory.

Sabrina Mitchell: We needed our staff to know where they could direct these patients if they needed to know about insurance, where they could direct these patients if they needed to know about transportation.

Sabrina Mitchell: And the patient navigator was instrumental in in helping with that and continues to be instrumental in helping us to create a across the board resource directory for our entire region that will be available to our providers.

Sabrina Mitchell: As I said, this is an ongoing process that we're doing as far as quality improvement. We plan to continue with the Plan-Do-Study-Act and one of the learning efforts that we learned in that is we included personal choice in tracking those refusals and trying to find barriers.

Sabrina Mitchell: As we began to do that in the beginning, we began to realize that if we ask the questions about the personal choice, many times it fell into the financial realm, the insurance realm, the transportation realm.

Sabrina Mitchell: So, one of the other areas that we were able to help the patients with, in order to get them into the correct resource to help them identify and be able to get the testing done.

Sabrina Mitchell: As a result of the interventions that we were able to implement, we saw an improvement in our cervical cancer screening rate from 31% to 46% which meant that we had a considerable amount of additional Pap smears that were performed over the period of the year. From January to October alone, there were 475 additional pap smears that we were able to get women in to have done. And as I said, we also offered the self-testing alone. So, we're not where we want to be.

Sabrina Mitchell: But we're headed in the right direction. And we will continue to utilize this as a resource to continue to work in that direction.

Sabrina Mitchell: Next slide, please.

Sabrina Mitchell: In summary, we have been able to utilize the patient navigator in order to look for patients that haven't had those screenings and to reach out to them and also to help with the education not only of the patients but of staff as well.

Sabrina Mitchell: Also, we have utilized tools that have been implemented in order to track disparities and barriers. And able to find resources and to provide education in order to address those barriers in order to help these patients get this testing done.

Sabrina Mitchell: And it is showing in our UDS data and the improvement that we've seen in our cancer screening rates, not only for cervical cancer.

Sabrina Mitchell: I might add we've also seen an increase in our breast cancer screening rates from 38% to 56% and we've also seen an increase in our colorectal screening rates from 36% to 41.5%.

Sabrina Mitchell: Again, not exactly where we want to finish, but we're continuing to work on it and we believe that with the things that we're continuing to implement and by finding these barriers, addressing these barriers that we're going to continue to see improvements.

Sabrina Mitchell: Thank you very much.

Helenka Ostrum: Thank you so much for that wonderful presentation and really highlighting how you dug deeper into those patient refusals to really get at how you can help patients directly.

Helenka Ostrum: It's my pleasure now to introduce our next two speakers. Dr. Elena Marin is a native of Brownsville, Texas. She graduated from the University of Houston School of Pharmacy, received her M.D. degree from Boston University School of Medicine, and completed her pediatric residency at Duke University Medical Center in 1986.

Helenka Ostrum: She began practicing Pediatrics in 1986 at Su Clinica as a National Health Service Corps scholar, was promoted to Medical Director, and in 1996 became Chief Executive Officer, the position she currently holds.

Helenka Ostrum: She currently serves on the Superior Health Plan and Zenith IPA Boards, as well as TACHC's HCCN Committee and the Clinical Integrated Network Board Executive Committee.

Helenka Ostrum: Dr. Marin and Su Clinica were instrumental in helping establish the UTHSC-San Antonio Regional Academic Health Center campus in 2002. Su Clinica provided the foundation and infrastructure for medical student education and housing for the Internal Medicine Resident Continuity Clinics.

Helenka Ostrum: She participated as Assistant Professor of Pediatrics to support medical students from San Antonio. As member of the UTRGV Medical School Community Advisory Committee and South Texas Medical School Foundation Board, Dr. Marin helped to support the establishment of the new UTRGV Medical School.

Helenka Ostrum: She has received numerous awards including the American Medical Women's Association "*Local Legend Award*" for her leadership in community service, the National Association of Community Health Centers Best Practice Poster Award, the Outstanding Citizen Award from UnidosUs, the UnidosUs Texas Affiliate of the Year Award and "*Angel de Mi Corazon*" Award for her leadership in fighting heart disease. Dr. Marin enjoys the Arts, traveling, church activities and spending time with her family.

Helenka Ostrum: Blanca Cavazos is the Clinic Manager for the Women's Health Center at Su Clinica. She has served in this capacity for 15 years. Blanca manages the three Women's Health Centers in Cameron and Willacy Counties. The Centers provide comprehensive Gyn and OB care. Su Clinica's service area is located on the southernmost tip of Texas and bordering Mexico.

Helenka Ostrum: Blanca has successfully collaborated with other entities such as UT School of Public Health in Brownsville, MD Anderson, and others to keep the Women's Health Centers up to date on women's health related education and research opportunities. Through these collaborations, Blanca can offer access, knowledge, and expertise to the medical staff and patients. She is passionate about the work and advocacy for women's health issues in these border communities. By keeping the women healthy, the entire family thrives.

Helenka Ostrum:
Outside of work, Blanca and her husband enjoy fishing and spending time with their granddaughter. Blanca is also mom to three amazing dogs.

Helenka Ostrum: So, I will turn it now over to you both. Thank you.

Dr. Elena Marin: Thank you. It's a pleasure to be here today. And I am very happy to be able to share all of the activities that we've been involved with to prevent cervical cancer. And so next slide.

Dr. Elena Marin: This is a picture of our Su Clinica Brownsville clinic. Next slide.

Dr. Elena Marin: And just a little bit of information about where we're located. As you can see at the southern tip of Texas, there are four red boxes there that represent counties and we are actually serving the two boxes there right next to the Gulf of Mexico.

Dr. Elena Marin: And we have four sites along the Texas-Mexico border and the Gulf of Mexico. Next slide.

Dr. Elena Marin: These are some of our community challenges. We are one of the poorest counties in the United States.

Dr. Elena Marin: We also serve a high number of uninsured individuals. We have a 43% uninsured and underinsured and about 40% of our patients are uninsured and is a reminder, as you know Texas was not one of the states that actually expanded Medicaid.

Dr. Elena Marin: And so that has hurt the access within the Rio Grande Valley and the entire state of Texas.

Dr. Elena Marin: We also have a subpopulation of migrant seasonal farm workers and some of the challenges with taking care of migrant seasonal farm workers are just the mobile population and the continuity of care for services.

Dr. Elena Marin: We're also along the border. So, it's been, we've had a long history of just traveling back and forth between Mexico and the United States, a lot of movement back and forth. We actually have an international bridge that connects Brownsville and Mexico.

Dr. Elena Marin: And so, we've been used to that and all of the challenges that come along with the border areas, including the recent surges in migrants that have been crossing.

Dr. Elena Marin: In addition to diabetes, hypertension, obesity, depression, cervical cancer is one of our priority conditions and we've been extremely active over the last 10 years in trying to address that.

Dr. Elena Marin: We also have emergency management issues with hurricanes. And as you know, vulnerable populations that are impacted with hurricanes and other emergencies are challenging and we are there to improve access to services and other necessary resources that they may need during an emergency.

Dr. Elena Marin: Next slide.

Dr. Elena Marin: I'm going to go through, very quickly, history highlights because I know we don't have a lot of time.

Dr. Elena Marin: We were started, way back in 1971, with Organizaciones Unidas and Catholic Charities became operational in 1971.

Dr. Elena Marin: I mentioned our migrant seasonal farm worker sub-population. 96% of our patients identify as Hispanic, majority of which are of Mexican-American descent. We have comprehensive services, including behavioral health.

Dr. Elena Marin: We have a very strong commitment to women's health services. They originally in the early years had a clinic birthing center.

Dr. Elena Marin: As a matter of fact, in 1986, when I came down as a pediatrician, they very quickly told me that I might be asked to attend a birth or examine a baby. And that was pretty shocking to me, I'd never seen that before.

Dr. Elena Marin: But, in those years where we collaborated together it was a wonderful experience with the team of certified nurse midwives, and nurse practitioners, and our OB team.

Dr. Elena Marin: Certified nurse midwives eventually moved over to the hospital, and they continue to provide services in the clinic as well as in the hospital and deliveries in the hospital, as well.

Dr. Elena Marin: We serve over 30,000 patients annually and we've had a long-standing economic partnership, as mentioned in the introductions.

Dr. Elena Marin: Next slide.

Dr. Elena Marin: So just a little bit about cervical cancer in the Rio Grande Valley. Cervical cancer rates and incidence of cervical cancer are 25% higher than the rest of Texas.

Dr. Elena Marin: And 55% higher than the rest of the country. We have lower rates of reported cancer screening and our rate of invasive cervical cancer for Hispanics in the Rio Grande Valley are double compared to non-Hispanic whites in Texas.

Dr. Elena Marin: Many are incurable at the time of diagnosis and as such we have a 36% higher mortality rate for Hispanics than non-Hispanic whites in Texas from the Rio Grande Valley.

Dr. Elena Marin: Next slide.

Dr. Elena Marin: So, what I want to talk about is making a collective impact is really important to us and we have used collaborative partnerships and research to really make a difference in our community.

Dr. Elena Marin: Next slide.

Dr. Elena Marin: Our collaborative research and planning partners that I'm going to talk about today is with our MD Anderson Cancer Network.

Dr. Elena Marin: And UT Health, University of Texas, Health Science Center at Houston, our School of Public Health, that we have very close relationships with.

Dr. Elena Marin: Next slide.

Dr. Elena Marin: What we wanted to do was we wanted to engage with like-minded and passionate partners. We wanted to identify barriers to care that we could actually meaningfully impact, to develop innovative interventions that would meaningfully impact our population, and to track our progress and utilize our CPI - continuous performance improvement - principles. Next slide.

Dr. Elena Marin: The barriers that we have identified here in the Rio Grande Valley, some of them are very similar to in the rest of the country, such as low health literacy.

Dr. Elena Marin: We had parental confusion regarding the HPV vaccines and in our culture in the initial phases when we were really promoting HPV vaccines. You know parents, were thinking that by giving a vaccine to their 11- and 12-year-olds that it was giving them permission to be sexually active.

Dr. Elena Marin: And that was a big problem and a big barrier for us. And we have since changed the way that we speak about HPV vaccines, you know, really focusing on the cancer prevention and that once the children are grown and married that we will, they will be protected from their partners if they had contracted HPV.

Dr. Elena Marin: And that has been successful for us. We have some inconvenient clinic hours, not in the sense that we, I mean, we do have Saturday clinics for women's health services but there are only a certain amount of providers and so the access right now is for after hours and during the weekday and for additional clinic appointments for Saturdays.

Dr. Elena Marin: We have lack of insurance and affordable copays. Lack of available transportation and even though they may have a car, it's possible that the women are at home taking care of children and the male partner is at work with the car and you know these are just issues that we don't think about but are really a barrier to access.

Dr. Elena Marin: Language barriers are not as difficult since we do have a lot of bilingual staff members that speak Spanish with their predominantly Hispanic population.

Dr. Elena Marin: There's fear and embarrassment of procedures. I think that's been talked about quite a bit. Fear of deportation if migrating across the border has been an issue for us, a health center and health system fragmentation have been issues.

Dr. Elena Marin: And then clinician knowledge and competence in more specialized procedures and other services. Next slide.

Dr. Elena Marin: So, the model that we were using, over the last 10 years has been really collaborating with academic and community partners.

Dr. Elena Marin: Improving health literacy for our patients, our community, and also our staff because we found that a lot of our staff did have health literacy issues about really what cervical cancer was all about and what HPV was and how that was important in educating our patients.

Dr. Elena Marin: And so, it was really important that we not only educate our patients and the community outreach, but also our staff who are actually taking care of our patients.

Dr. Elena Marin: We also wanted to improve access to clinic services. Follow evidence-based screening guidelines, occasionally they change, and we need to make sure that everybody is following evidence-based guidelines.

Dr. Elena Marin: We actually use tele-mentoring through an ECHO project that was specifically targeted for cervical cancer.

Dr. Elena Marin: Case presentations and there were also some other countries that participated in that as well. That was bi-weekly and that was free CME that was provided during those ECHO sessions, and we continue to this day to participate for cervical cancer, those ECHO programs.

Dr. Elena Marin: We also wanted to introduce additional providers to be able to perform colposcopy and LEEP training to sort of close the loop that once we identified some abnormalities and dysplasia,

Dr. Elena Marin: that we would be able to do biopsies and we would actually be able to treat those high-grade dysplasias that we found.

Dr. Elena Marin: And then promoting prevention using HPV vaccines was really, really important to us in reducing cervical cancer mortality. Next slide.

Dr. Elena Marin: So, I'm just going to go through quickly some timeline of some activities that we've been involved with.

Dr. Elena Marin: Starting in January of 2014, we began the ECHO telehealth CME conferencing. In March of 2014 a colposcopy and LEEP equipment from the Cancer Institute was donated to Su Clinica.

Dr. Elena Marin: We had three mid-level clinicians, two certified nurse midwives, one family nurse practitioner, trained to perform the colposcopies. And we had one in-house OB/GYN trained with the new LEEP equipment. Next slide.

Dr. Elena Marin: And we began performing colposcopies and LEEP procedures. LEEP procedures, a loop electrosurgical excision procedure for high-grade dysplasia and it is very precise in in being able to excise those abnormal cells.

Dr. Elena Marin: In May 2014, we had our first annual Mother's Day health fair clinic, which was promoting cervical cancer screenings.

Dr. Elena Marin: In June of 2014, we actually had promotoras or community health workers and navigators from the School of Public Health began work with Su Clinica assisting with education both inreach and outreach and actually helping us to schedule patients that were overdue for their cancer screening test.

Dr. Elena Marin: In March of 2016 we were proud that within the span of 24 months we were able to provide 82 LEEP procedures at Su Clinica.

Dr. Elena Marin: And in August of 2017, we started talking about high-resolution micro-endoscopy with MD Anderson. And so, we participated in a research project that actually took an instrument, a microscope, that was, during the Pap testing would actually be able to see the cells and distinguish all of the different grades of pathology. And right there and then, instead of doing the Pap and sending it off to be seen by the pathology, we were able to identify those abnormal cells.

Dr. Elena Marin: In the beginning, we were actually comparing the accuracy of using both techniques with doing the microscopic evaluation, doing the biopsy, and then comparing the results, which came back very accurate. Next slide.

Dr. Elena Marin: We also partnered with the Texas Association of Community Health Centers in Trauma Informed Care.

Dr. Elena Marin: And I won't go into a lot of discussion about that because Dr. Danan did describe all the work, that she did at the VA system.

Dr. Elena Marin: But suffice it to say when we had the surge in the migrants coming across, we were very interested in making sure that our entire organization had training in trauma-informed care.

Dr. Elena Marin: And so that in our women's health center we were able to make sure that we were respectful, provided dignified services, that we didn't just rush in, etc.

Dr. Elena Marin: They may have had some history of sexual trauma. Those kinds of things that were discussed earlier and we made some changes in our procedures and how we wanted to make sure that our women felt safe and that they develop the trusting relationship they needed with their care provider.

Dr. Elena Marin: In October of 2019 we implemented Project Jupiter and we decided that we wanted it to be a whole family affair. So, we invited the entire family to be screened. The women to be screened for cervical cancer, the children to be given immunizations.

Dr. Elena Marin: And the parents and the men to be educated on how important it was for the young men to also receive immunizations as well.

Dr. Elena Marin: In the summer of 2023, MD Anderson Cancer Center, we signed a letter of support for HPV vaginal self-sampling research. We are pending FDA approval and also a grant that has been applied for.

Dr. Elena Marin: And just as we are looking at self-sampling and all, and it's not for everyone, we too would like to understand all of the issues surrounding the acceptability of self-testing within our clinic.

Dr. Elena Marin: And one of the things that I'm very excited about is, I really feel that this could be a game changer for us, especially in the population of patients that go to our internal medicine clinic where they're referred off to the women's health center and they may not show up for the appointment.

Dr. Elena Marin: Where we could actually look at self-testing just like we look at a urinalysis test or anything else in the laboratory that we could do prior to.

Dr. Elena Marin: And so, in the event that they no-show to the appointments, we will have at least gotten a screen.

Dr. Elena Marin: And if positive, then we would, you know, determine that they were high risk and we would reach out to them and, you know, really focus on getting them into our women's health center.

Dr. Elena Marin: This would not replace the annual wellness women's exam, but it would allow a safety net for us to provide that.

Dr. Elena Marin: So, we're very excited about working with them on that project. Next slide.

Dr. Elena Marin: And obviously the Accelerating Cancer Screening HRSA grant was very important to us.

Dr. Elena Marin: We have, we're actually doing all three of those cancers and we were able to bring in a cancer prevention manager to coordinate breast, cervical, and colorectal cancer screening activities and reporting at our clinic. We added three navigators.

Dr. Elena Marin: We added additional Project Jupiter events. This allowed us to add providers to our Saturday women's health clinics and extend our weekday clinics and continued partnership with MD Anderson. Next slide.

Dr. Elena Marin: These are just some photos of some of our Project Jupiter events. They're theme based.

Dr. Elena Marin: They are, you know, beach themes or Halloween themes and you know those kinds of things to really get families excited about coming out. And we also have community partners that help us put those on. Next slide.

Dr. Elena Marin: Some of our community partners. This is just a list of, we usually have about 17 to 20 participants. These are just a few of our community partners. Next slide.

Dr. Elena Marin: And just between April of 2014 to December of 2023 we have provided 387 LEEP procedures and 2,179 colposcopies.

Dr. Elena Marin: We're so proud of that and being able to not only educate and screen and you know we're able to actually diagnose and actually treat. And that has been very, very, helpful to our patients. Next slide.

Dr. Elena Marin: And these are just some numbers of our UDS numbers for cervical cancer screening when we first started in 2014 and working with MD Anderson in the School of Public Health in 2015.

Dr. Elena Marin: You can see our cervical cancer screening jumped up to 87.14%.

Dr. Elena Marin: Everybody was engaged. There was a lot of activity going on there. And then you can see in 2021 post-COVID what happened.

Dr. Elena Marin: And then in 2022, we actually worked very hard to bring our ladies in and to bring up our cancer screening numbers.

Dr. Elena Marin: And this year we're hoping that to, at least, hit the same number or better. One thing I did want to mention is that the higher percentage that you achieve, it's harder to keep up with.

Dr. Elena Marin: And a lot of times our patients have come in for, we've able to bring them in for their cancer screening.

Dr. Elena Marin: They are you know they are thinking that well I already had my cancer screening test and so you know it's not that important that was negative, etc.

Dr. Elena Marin: So, you always have to continue to convince them how important it is to get those tests regularly to prevent cancer. Next slide.

Dr. Elena Marin: And so, in summary, we really want to impart that collectively impacting population health is a team sport.

Dr. Elena Marin: Do not try to go it alone. And we have been very, very happy with our partnerships aligning with cancer institutes and other academic institutions significantly improves availability of resources, infrastructure for services, and opportunities for translational research and clinical education.

Dr. Elena Marin: Translational research meaning let's do something that we can quickly put into place. It's practical, meaningful, and it will reduce inequities and disparities.

Dr. Elena Marin: Don't be afraid to change, to be creative or visionary in how you provide services. Train, educate and support your staff as this helps them find meaning in their everyday work.

Dr. Elena Marin: What we have found is the more knowledge they have and understanding of what they're doing and how they are contributing to population health and making a difference in their patients' lives.

Dr. Elena Marin: You know, this has been very important to us. Being able to complete the loop of education, prevention, screening, navigation, and treatment in the environment of a patient-centered medical home and trusted referral partner is we've believed a model of excellence.

Dr. Elena Marin: And the most important that I'd just like to leave you with is no woman should ever have to die of cervical cancer as it is 100% preventable and just a little a shout out to HRSA for being so supportive of cancer prevention. And I would like to just make a plug that if we want to significantly reduce cervical cancer in the United States, we need to start vaccinating.

Dr. Elena Marin: And my suggestion and this is my opinion, I think that it would be great if HRSA could collect data on HPV vaccination rates from all of the community health centers, you know, for a couple of years, see where we are. And then try to move that needle. I think it would make a tremendous impact on what we're trying to achieve. Thank you.

Helenka Ostrum: Thank you so much for your presentation. I really appreciate how you emphasized partnerships and the importance of that as we're tackling this big issue but an issue that we all have stated has solutions that we all can work hard to achieve.

Helenka Ostrum: In conclusion today, we are out of time for questions. However, if you have any questions, you can contact the HRSA Office of Women's Health at HRSAOWH@hrsa.gov.

Helenka Ostrum: I invite you all to connect more with HRSA and learn more about our agency.

Helenka Ostrum: The link to the webinar recording will be posted on the HRSA Office of Women's Health webinar webpage. I've included that link in the chat. That's www.hrsa.gov/office-womens-health/webinars.

Helenka Ostrum: I encourage you to visit HRSA.gov and sign up for HRSA eNews, a bi-weekly email of comprehensive HRSA news. And you can also sign up for the HRSA OWH newsletter. Have a wonderful day.

Helenka Ostrum: Thank you all so much to our presenters.

End of Transcript